

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-020694

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 38 R Primary Registration District No. 3039 Registrar's No. 226

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY KINN		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MISSOURI b. COUNTY CHARITON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BROOKFIELD		Length of stay in 1b	c. CITY OR TOWN SUMNER
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pershing Memorial Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) LUCY M BURTON		4. DATE OF DEATH MAY 21 - 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18-1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (City and state or country) MT. AUBURN ILL.
13a. FATHER'S NAME JAMES W. Stobaugh		14. NAME OF HUSBAND OR WIFE Keshie Burton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. E.H. BURTON SUMNER MO	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bowel Obstruction PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1963 to 1963 and last saw him/her alive on 5-21-63 Death occurred at 755 PM m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) B.D. Howell M.D. 22b. ADDRESS Brookfield Mo 22c. DATE SIGNED 5-22-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/23/63	23c. NAME OF CEMETERY OR CREMATORY LAKE SIDE	23d. LOCATION (City, town, or county) (State) SUMNER MO
24. FUNERAL DIRECTOR S. L. Schiparo ADDRESS MENDON MO		25. DATE RECD. BY LOCAL REG. 5-23-63 26. REGISTRAR'S SIGNATURE Carroll Watson	

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

A. R. Lipard

Licensed Embalmer No.

3970

P. O. Address

MENDON MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.